STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, monitor, and provide appropriate clinical oversight of a urinary collection device used to manage chronic urinary incontinence for 1 of 1 resident (R1) reviewed for urinary incontinence.Findings include:R1's face sheet printed 6/3/26, identified diagnoses including chronic kidney disease stage 3, lymphedema (swelling caused by a buildup of fluid), chronic combined systolic and diastolic heart failure, chronic right-sided heart failure, benign prostatic hyperplasia (enlarged prostate) with urinary symptoms, localized edema (swelling), acute cystitis with hematuria (bladder infection with blood in the urine), and muscle weakness.R1's care area assessment (CAA) for urinary incontinence dated 2/5/26, identified urinary incontinence as an actual problem. The CAA identified R1 required assistance with toileting and was occasionally incontinent of urine. Contributing factors identified in the assessment included pain, restricted mobility, benign prostatic hyperplasia (enlarged prostate), congestive heart failure, use of diuretic medications, and opioid medications. The CAA further identified urinary incontinence placed R1 at risk for urinary tract infections, skin injury, loss of dignity, social isolation, and further functional decline. The assessment determined the issue would be addressed through care planning.R1's quarterly Minimum Data Set (MDS) dated [DATE], identified cognition was intact. The MDS further identified R1 was always incontinent of urine and received diuretic medication.R1's care plan identified a focus, revised 8/18/25, that R1 had a history of urinary tract infections (UTIs) and benign prostatic hyperplasia (enlarged prostate). The care plan goal directed staff to prevent skin breakdown related to incontinence and brief use. Interventions initiated 11/9/22, directed staff to encourage fluid intake during the morning and afternoon, limit fluids during the evening, avoid foods and beverages that may irritate the bladder, and monitor for signs and symptoms of a UTI, including pain, burning, blood in the urine, cloudy urine, decreased urine output, foul-smelling urine, fever, chills, changes in mental status, and changes in behavior. An additional intervention initiated and revised 8/18/25, identified R1 preferred use of a urinal, refused briefs, would request assistance as needed, and had PRN orders for a condom catheter. An additional care plan focus, revised 2/12/24, identified R1 had a self-care deficit related to a history of fractures, limited mobility, and pain. The care plan goal directed staff to maintain R1's current level of function with bed mobility, transfers, eating, dressing, toileting, and personal hygiene. An intervention revised 11/15/24, directed staff to assist with toilet use by offering help to the bathroom and assistance with emptying the urinal upon arising, before and after meals, and at night.R1's Kardex dated 6/3/26, identified R1 preferred use of a urinal, refused briefs, and would request staff assistance as needed. The Kardex directed staff to assist with emptying the urinal and identified PRN condom catheter orders. The Kardex further directed staff to offer assistance with toileting and empty the urinal upon arising, before and after meals, and at night.R1's progress note dated 5/2/26 at 11:54 a.m., identified R1 required standby assistance to transfer to the toilet and extensive assistance with personal care and dressing. The note further identified R1 was unable to control his urine stream, was incontinent of urine, and left the urinal in his pants.R1's progress note dated 5/8/26 at 4:23 p.m., identified R1 reported constant urinary dribbling and stated he kept a urinal between his legs at all times because he was afraid of spilling urine. R1 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further reported his penis was enlarged from having it in the urinal all the time. Staff educated R1 that he could rest in bed or a recliner and request assistance with the urinal before transferring to prevent spills. The note further identified R1 agreed to lie in bed and was later observed sleeping.R1's progress note dated 5/25/26 at 1:55 a.m., identified R1 returned from the hospital with a diagnosis of cystitis (bladder infection). The note further identified the provider recommended discontinuing use of the external condom catheter until the urinary infection was treated and cleared R1 to use a urinal.During a phone interview on 6/4/26 at 9:34 a.m., LPN-B stated the Geiserailie urinary collection device was first applied approximately two days before R1 was sent to the emergency department on 5/24/26 and was reapplied on 6/1/26. When asked what assessment she completed before directing staff to apply the device on 5/23/26, LPN-B stated, I didn't do one, we were just trialing it. LPN-B acknowledged she did not document an assessment on 5/23/26 or when the device was reapplied on 6/1/26 and stated, I didn't do a formal one. LPN-B further stated no assessments had been completed and no care directions had been developed regarding prevention of skin breakdown, reduction of infection risk, or monitoring for complications associated with device use. When asked how she determined the device was safe to continue using after the hospital documented penile edema and cystitis, LPN-B stated she was instructed by the interim director of nursing to continue the trial. When asked what findings would indicate the device was causing a complication, LPN-B stated, I am not sure if he would have gotten a rash, infection .Review of R1's toileting response history identified staff documented R1's urinary continence as not rated due to use of an indwelling catheter on 5/23/26 at 6:25 p.m., 5/24/26 at 5:59 a.m., 9:36 a.m., and 8:35 p.m., 6/1/26 at 7:17 p.m., and 6/3/26 at 5:59 a.m. The toileting response history further identified staff documented R1's urinary continence as not rated due to condom catheter on 6/3/26 at 2:05 p.m. and 9:35 p.m.R1's weekly skin checks dated 5/4/26, 5/11/26, 5/18/26, and 5/27/26, identified R1's skin was warm and dry, skin color was within normal limits, skin turgor was normal, and no external devices were present. The skin did not identify use of the urinary collection device or document assessment of the penile skin and surrounding tissue related to device use.In review of R1's record there was no indication a physician order had been obtained for the use of the Geiserailie device nor evident the care plan was revised. Further not evident of ongoing assessments and monitoring of device effectiveness and skin integrity.During an observation and interview on 6/2/26 at 3:48 p.m., R1 was observed seated in his wheelchair in his room. R1 stated, I have a condom catheter. It's the penis and the thing that goes over it. It's not inside. Observation identified a drainage bag containing urine was positioned in a white pillowcase attached to the left side of the wheelchair. R1 stated he was unsure how often staff emptied the bag and reported staff changed the device when it needed to be changed. R1 stated staff were responsible for managing the device and he did not know how it worked. R1 denied having sores or pain to his penis. R1 stated the device was being used because urine would leak from the urinal and result in a wet bed.During an interview on 6/2/26 at 4:37 p.m., nurse practitioner (NP)-A stated R1 was using an external urinary collection device obtained by the facility. NP-A stated the device was not a condom catheter but consisted of a support garment with a plastic receptacle that fit over the penis and drained into a closed urinary drainage bag. NP-A stated use of the device allowed R1 to sleep in bed rather than in his wheelchair with a urinal positioned between his legs. NP-A further stated the device had recently been reordered after it was discarded during R1's recent hospital stay. When asked about skin concerns related to the device, NP-A stated she was not aware of any skin issues. NP-A stated she approved use of the device but had not written orders regarding use of the device, routine maintenance, cleaning procedures, skin integrity monitoring, or infection prevention measures.During an interview on 6/3/26 at 12:14 p.m., nursing assistant (NA)-A stated she had emptied the drainage bag but had not applied the device. NA-A stated she had not received instructions regarding changing, cleaning, maintenance, or skin assessment related to the device and was unaware of any procedures for monitoring complications.During an observation and interview on 6/3/26 at 12:40 p.m., R1 was observed lying in bed with NA-A present. R1 was using an external (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary collection device consisting of a Y-shaped collection cup positioned around the penis and connected to tubing and a drainage bag. The penis was observed within the collection cup. R1 stated staff did not change or clean the device and reported, I have had it in for about 3 days. The drainage bag was observed attached to a Velcro strap and placed inside a black bag hanging from the side of the bed. NA-A stated she believed the drainage bag was intended to be secured to R1's leg; however, the tubing was too long. NA-A stated she initially hung the drainage bag from the side of the bed, later placed it on the bed, and was unsure how it should be positioned. NA-A further stated she obtained a Velcro strap from the supply room and used it to secure the drainage bag. The support garment surrounding the collection cup had dried urine staining and a urine odor. When the drainage bag was placed on the bed, R1 stated urine could back flush and requested the bag be hung over the side of the bed. NA-A complied and repositioned the drainage bag.During an interview on 6/3/26 at 1:02 p.m., NA-B stated staff were not provided instructions regarding cleaning, changing, or maintaining the urinary collection device. NA-B stated she checked the waistband for irritation but would need to remove the device to assess the penile skin and had not been directed to do so. NA-B further stated she was unaware of how often the device should be changed and had not received guidance regarding monitoring for complications.During an interview on 6/3/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated she was unable to locate practitioner orders addressing use of the device and was not aware of its care or maintenance requirements. LPN-A stated there were no current orders directing staff to assess skin integrity related to device use and she was unsure whether staff were removing the device to perform skin assessments.During an interview on 6/3/26 at 3:21 p.m., the interim director of nursing (IDON) stated she initiated use of the Geiserailie three-piece urinary collection system for R1. IDON stated a physician or nurse practitioner order was not obtained prior to implementation of the device. The IDON further stated the care plan was not updated, no baseline assessment was completed prior to implementation, and no routine assessments were established after implementation. Staff were not provided training regarding application, cleaning, emptying, monitoring, or removal of the device and manufacturer instructions were not available. IDON stated there was no established process or frequency for assessment of R1's penis or foreskin while using the device. IDON further stated the nurse practitioner was notified after the device had already been implemented. IDON could not determine whether penile edema was present prior to implementation because assessments had not been completed or documented.During a phone interview on 6/4/26 at 10:05 a.m., the medical director verified a provider order was not obtained prior to implementation of the Geiserailie urinary collection device. The medical director stated the intervention should have been care planned and staff provided direction regarding application, monitoring, cleaning, and maintenance of the device. Nursing staff should have completed and documented baseline and ongoing assessments of the penis and foreskin. The medical director noted the emergency department documented distal penile edema and cystitis, although no obvious penile infection was identified. The medical director stated the skin should be assessed at least daily, the device should be changed daily, and distal penile edema should be reported to the provider. A provider order should be obtained prior to initiating any new urinary collection device.Facility undated policy, Catheter Care, identified that urinary drainage systems should be maintained as a closed drainage system. The policy directed staff to secure the drainage bag with straps, observe the skin for irritation or changes and report concerns to the licensed nurse, empty the drainage bag routinely to prevent overfilling, and clean drainage bags according to established procedures. The policy further identified drainage bags should be cleaned with appropriate cleaning solutions and allowed to dry before reuse. The policy further identified staff were to observe the skin for irritation or changes and report concerns to the licensed nurse.Contrary to facility policy, staff did not routinely assess the skin, were not instructed regarding cleaning procedures, improvised methods for securing the drainage bag, and were unable to describe maintenance requirements for the urinary collection system.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess pain, re-evaluate the effectiveness of the pain regimen, ensure accurate and complete documentation, and notify the physician of break through pain for 1 of 1 resident (R1) reviewed for pain management. Findings include:R1's face sheet printed 6/3/26, identified diagnoses of pain in left elbow, generalized muscle weakness, cervical spinal stenosis (narrowing of the spinal canal in the neck), lumbar spinal stenosis (narrowing of the spinal canal in the lower back), low back pain, anxiety disorder, and major depressive disorder (depression).R1's Care Area Assessment (CAA) dated 2/5/26, identified pain as an actual problem and triggered due to a pain numeric intensity rating of 7/10. The CAA identified multiple diagnoses and conditions that could contribute to pain, including cardiac disease, pneumonia, gastroesophageal reflux disease (GERD), arthritis, and dental problems. The CAA further identified pain could result in impaired ability to perform ADLs, reluctance to participate in therapy, poor healing, falls, and further functional and cognitive decline. The CAA identified pain would be addressed through care planning.R1's quarterly Minimum Data Set (MDS) dated [DATE], identified cognition was intact. The MDS indicated R1 received a scheduled pain medication regimen and did not receive non-pharmacological pain interventions during the 5-day look-back period. R1 reported experiencing pain frequently and rated his worst pain as 3/10. The MDS further identified pain occasionally made it difficult for R1 to sleep at night and occasionally limited day-to-day activities. R1 was independent with most activities of daily living (ADLs).R1's care plan dated 1/16/24, identified a focus that R1 had generalized chronic and acute pain related to multiple chronic conditions and diagnoses, including osteoarthritis. The care plan noted pain could affect R1's ability to perform activities of daily living ADL's and quality of life. Interventions initiated 9/23/22, directed staff to assess pain using the Numeric Pain Scale (0-10); monitor and record pain characteristics, including quality, severity, location, onset, duration, aggravating factors, and relieving factors; monitor and document side effects of pain medications; report changes in activity attendance patterns or refusal to attend activities related to signs, symptoms, complaints of pain, or discomfort; notify the health care provider if interventions were unsuccessful or if pain represented a significant change from R1's usual pain pattern; and provide R1 and family information regarding pain and pain management options. An additional intervention initiated 2/2/24, directed staff to attempt non-pharmacological pain management interventions, including ice packs.Although R1's care plan identified R1's chronic and acute pain and included interventions for assessment, monitoring, reporting, medication side effects, provider notification, and non-pharmacological interventions, the care plan did not address resident-specific pain management goal or desired outcome such as acceptable pian level or desired outcome.R1's physician order summary identified an order dated 10/25/22, for acetaminophen tablet 500 milligram (mg), give 2 tablets by mouth three times daily for pain. On 5/6/26, directed staff to administer oxycodone HCl (narcotic pain medication) oral tablet 5 mg, give 2.5 mg by mouth every six hours as needed for pain rated 2-5 and give 5 mg by mouth every six hours as needed for pain rated 6-10. An additional order dated 5/11/26, directed staff to administer gabapentin (medication for nerve pain) 300 mg, give 2 capsules by mouth three times daily (600 mg three times daily) for neuropathy.R1's May 2026 MAR, progress notes, and occupational therapy documentation dated between 5/11/26 and 5/21/26 were reviewed and identified R1 continued to report left arm pain that interfered with daily activities despite ongoing treatment. The MAR identified R1 received PRN oxycodone on 47 occasions between 5/7/26 and 5/31/26 for reported pain ratings ranging from 6/10 to 10/10. Follow-up documentation identified the medication was ineffective on 13 occasions and effectiveness was documented as unknown on four occasions. When oxycodone was documented as ineffective, follow-up pain ratings remained elevated at 6/10, 7/10, 8/10, 9/10, and 10/10. Record review did not identify documentation that nursing staff (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed additional pain assessments, notified the provider that prescribed pain interventions were unsuccessful, or revised the pain management plan following the repeated ineffective medication administrations. Although R1's care plan directed staff to attempt non-pharmacological pain management interventions, record review identified limited documentation of non-pharmacological interventions being offered or implemented. The only documented intervention following an ineffective pain medication administration was application of a cold compress on 5/15/26. Record review did not identify consistent documentation of other interventions attempted or offered such as ice, positioning, bracing, sling use, activity modification, rest periods, or other measures to address R1's ongoing pain.R1's progress note dated 5/7/26 at 11:03 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as Unknown. The note indicated R1 reported increased pain with repositioning in the wheelchair. Record review did not identify documentation of a follow-up pain assessment, evaluation of the effectiveness of the medication administration, or additional interventions to address the resident's reported increase in pain.R1's progress note 5/9/26 at 2:21 a.m., R1 received oxycodone 5 mg for pain rated 6-10/10. Follow-up documentation indicated the administration was ineffective, and R1 continued to report pain at a level of 6/10.R1's progress note dated 5/11/26 at 6:19 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as Unknown. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.R1's physician visit dated 5/11/26, identified R1 was evaluated for left arm pain. The physician documented R1 reported pain at the level of the elbow that sometimes extended toward the hand and had been present for approximately one week. R1 denied chest pain, denied radiation from the shoulder to the elbow, and denied trauma. Physical examination identified left elbow pain on palpation of both the medial (inside) and lateral (outside) epicondyles (bony areas on each side of the elbow) and pain with resisted extension. The physician assessed bilateral epicondylitis (inflammation and irritation of the tendons attached to the elbow, commonly known as tennis elbow), discussed use of a counterforce brace, encouraged R1 to minimize use of the left hand, ordered a therapy consultation, and increased gabapentin to 600 mg three times daily.R1's Occupational Therapy (OT) note dated 5/12/26, identified R1 reported constant left elbow pain rated 10/10, describing the pain as, The whole elbow - it's in so much pain, you wouldn't believe it. OT documented the pain limited R1's quality of life and daily functional tasks. Following ultrasound treatment, R1 reported temporary improvement from 10/10 to 0/10; however, nursing staff reported severe pain returned within 20 minutes.R1's progress note 5/13/26 at 7:21 p.m., R1 received oxycodone 5 mg for pain rated 6-10/10. Follow-up documentation indicated the medication was ineffective, stating pain still same, and R1 continued to report pain at 9/10.R1's progress note dated 5/14/26 at 2:22 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication.R1's OT note dated 5/14/26, identified R1 continued to report constant left elbow pain rated 10/10 at rest. OT documented the pain was tender to touch, limited quality of life and daily functional tasks, increased with reaching, and caused grimacing with elbow movement. R1 reported continued use of pain medication, topical cream, and ice packs with ongoing pain.R1's progress note dated 5/15/26 at 7:15 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication.R1's progress note dated 5/20/26 at 12:13 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication.R1's progress note dated 5/21/26 at 8:54 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 10/10 following administration of the medication.R1's OT note dated 5/21/26, identified R1 reported constant left elbow pain rated 10/10 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that limited quality of life and daily functional tasks. The OT documented the left elbow was tender to touch and pain increased with reaching. Nursing staff reported R1 had received pain medication approximately 4.5 hours earlier and could receive additional pain medication every six hours. R1 reported the best his pain improved with medication was 6/10. OT provided a left-sided half lap tray and an ice pack for pain management. After approximately 10 minutes of using the lap tray, R1 reported pain improved from 10/10 to 6/10; however, the pain remained constant. Post-treatment documentation identified left elbow pain remained at 6/10.R1's OT note dated 5/22/26, identified R1 stated, my elbow hurts so much. I'm not doing anything with it today, and declined stretching and strengthening activities due to pain.R1's progress note dated 5/22/26 at 9:10 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 9/10 following administration of the medication.R1's progress note dated 5/23/26 at 1:16 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as Unknown. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.In review of R1's record between 5/11/26 (increase of the gabapentin) through 6/3/26 there was no indication R1's pharmacological pain management regimen in conjunction with non-pharmacological interventions was re-evaluated for effectiveness.R1's progress note dated 5/24/26 at 8:57 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication.R1's progress note dated 5/24/26 at 6:20 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 8/10 following administration of the medication.R1's progress note dated 5/24/26 at 10:15 p.m., identified R1 complained of severe left arm pain that was not relieved by PRN oxycodone, scheduled acetaminophen, or elevation of the arm. Due to persistent pain, the on-call provider ordered transfer to the emergency department for evaluation.R1's emergency department (ED) note dated 5/24/26, identified R1 was transferred to the emergency department for left arm pain. The emergency department provider documented R1 reported several days of non-traumatic left forearm and wrist pain and denied recent falls or trauma to the arm. Physical examination identified range of motion of the left shoulder, elbow, and wrist was intact with no significant tenderness, redness, or swelling. X-rays identified no acute fracture or dislocation of the left wrist or forearm. The emergency department provider documented R1's pain improved after receiving pain medication and discharged R1 back to the facility with a clinical impression of left arm pain. The ER visit did not include any new orders or treatment plan. R1's progress note dated 5/25/26 at 12:23 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. The note indicated R1 stated the pain level didn't change much following administration of the medication. Follow-up documentation identified R1 continued to report pain at a level of 10/10.R1's progress note dated 5/25/26 at 11:45 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as Unknown. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.R1's progress note dated 5/26/26 at 1:21 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as Unknown. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.R1's progress note dated 5/26/26 at 9:53 a.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 6/10 following administration of the medication.R1's OT note dated 5/26/26, identified R1 reported constant left elbow pain rated 10/10 at rest. Nursing staff reported R1 had recently been sent to the emergency department due to uncontrolled left upper extremity pain and returned to the facility with no changes to the pain management regimen. OT documented R1 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued to receive oxycodone and use ice packs for pain management. OT assessed the left upper extremity and applied kinesiology tape (a specialized elastic therapeutic tape used to provide support, reduce pain, and improve movement) to the elbow for lateral epicondylitis. Following the intervention, R1 reported immediate improvement in pain control and stated his pain decreased from 10/10 to 9/10. R1 described the pain as feeling like when you hit your funny bone. OT further documented R1 actively participated in treatment and reported improved pain management with use of kinesiology tape.R1's progress note dated 5/26/26 at 11:23 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective. Follow-up documentation identified R1 continued to report pain at a level of 7/10 following administration of the medication.R1's occupational therapy (OT) note dated 5/28/26, identified OT received an elbow brace and applied it after removing the kinesiology tape. OT documented no skin irritation was present. Upon application of the brace, R1 smiled and stated, That feels good! OT educated R1 regarding use of the brace and encouraged positioning that promoted elbow extension. OT also provided education to nursing staff regarding the purpose and use of the elbow brace. Nursing staff reported R1 had been spending more time resting in bed and a certified nursing assistant reported R1 had been in a lot of pain earlier. OT requested an order for R1 to wear the left elbow brace as needed and for nursing staff to complete daily skin checks.R1's progress note dated 5/28/26 at 2:02 a.m., documented oxycodone 2.5 mg administered for pain rated 2-5. The effectiveness of the medication was documented as Unknown. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.R1's progress note dated 5/31/26 at 1:39 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10 was ineffective and lacked a follow up pain scale rating.R1's progress note dated 5/31/26 at 1:39 p.m., documented oxycodone 2.5 mg administered for pain rated 2-5 was ineffective. The note indicated R1 continued to rate the pain at 10/10 following administration of the medication.R1's medication administration record (MAR) dated 6/1/26 through 6/3/26 identified acetaminophen and gabapentin were administered as prescribed. Review of the MAR further identified R1 received PRN (as needed) oxycodone on seven occasions between 6/1/26 and 6/3/26 for reported pain ratings ranging from 6/10 to 10/10. Six of the seven administrations were for pain ratings of 7/10 or greater, including documented pain ratings of 9/10 and 10/10. Follow-up documentation identified the effectiveness of the medication was unknown on two occasions despite facility expectations to evaluate the effectiveness of pain management interventions.R1's OT note dated 6/1/26, identified R1 reported left elbow pain that comes and goes and rated the pain 7/10 at rest while lying in bed with the elbow extended. OT documented R1 was not feeling well and remained in bed for lunch. R1 reported increased left elbow pain rated 10/10 when sitting at the edge of the bed. OT further documented R1 was not wearing the prescribed elbow brace and staff were unable to locate it despite searching R1's room and contacting other staff. R1 agreed to application of kinesiology tape (a specialized elastic therapeutic tape used to provide support, reduce pain, and improve movement) to the left elbow and reported mild pain relief following the intervention.R1's progress note dated 6/1/26 at 8:46 p.m., documented oxycodone 5 mg administered for pain rated 6-10/10. The effectiveness of the medication was documented as Unknown. The note further indicated R1 continued to complain of pain in the left arm following administration of the medication. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.During an observation and interview on 6/2/26 at 3:48 p.m., R1 was observed seated in a wheelchair in his room. During the interview, R1 suddenly bent to the left side, exhibited facial grimacing, moaning, and crying, and stated he was experiencing left elbow pain that radiated down his arm into his fingers. R1 rated his pain as 10/10 and later stated his pain was a 12. R1 stated staff should allow him to receive pain medication every four hours and reported staff had informed him it was too early for his next pain medication, and he would need to wait an additional two hours. R1 repeatedly stated staff were allowing him to suffer in pain and reported delays in receiving pain medication were worse on the evening shift. R1 was observed (continued on next page)

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	245207	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	holding his left arm and hand, rocking back and forth, crying, and keeping his eyes closed while reporting pain. R1 described the pain as feeling like his funny bone had been hit. R1 stated the pain affected his sleep and had been present for years. R1 further stated acetaminophen helped his pain; however, he continued crying and stated he could not handle the pain. The surveyor left the room to notify nursing staff of R1's reported severe pain.During an interview on 6/2/26 at 4:03 p.m., registered nurse (RN)-A was informed R1 was experiencing pain rated as a 12 in the left elbow, was doubled over in pain, and was crying. When asked whether she would assess R1's pain, RN-A stated the provider was aware of R1's left elbow pain and confirmed R1 had reported pain levels as high as 12 out of 10 in the past. RN-A stated R1 received oxycodone 5 mg at 12:20 p.m. for left arm pain and could receive oxycodone every six hours as needed (PRN). RN-A stated R1 also received scheduled acetaminophen 1,000 mg three times daily. R1's left elbow pain was chronic, and staff utilized alternative pain management measures including ice packs, relaxation, distraction, and reminders not to rest his left arm on hard surfaces. RN-A stated R1 requested additional oxycodone at approximately 3:00 p.m.; however, it was too early for another dose based on the physician's order. RN-A had no additional medication available to administer for pain at that time. RN-A would assess R1's pain and document the assessment in a progress note. When asked under what circumstances she would notify the provider regarding R1's ongoing severe pain, RN-A stated the provider was aware of the pain but did not identify any circumstances that would prompt additional provider notification.During an observation and interview on 6/2/26 at 4:13 p.m., R1 was observed seated in his wheelchair holding his left arm, moaning, and crying. At 4:14 p.m., RN-A entered the room and asked R1 whether he would like to lie down to help him relax. R1 declined and stated he wanted to remain up to eat supper. RN-A offered to adjust R1's ice pack; however, R1 stated the ice pack did not help his pain. RN-A did not ask R1 to rate his pain or otherwise assess the characteristics, location, severity, aggravating factors, or relieving factors associated with the pain and stated she could clearly see he was in pain. When asked how she would document her pain assessment, RN-A stated she could clearly observe R1 was experiencing pain. RN-A further stated the physician was aware of R1's pain and then exited the room. During the interview, R1 continued to cry and reported a constant burning pain that originated in his left elbow and radiated into his fingers, causing tingling in his thumb, index finger, and middle finger. R1 stated the pain occasionally lessened for a few minutes but quickly returned. R1 reported he had recently been evaluated at the hospital for the pain, but no cause had been identified. The pain also caused neck pain and sensitivity to touch. R1 reported the pain had worsened since admission to the facility and that pain medication provided only a few hours of relief. R1 repeatedly cried and stated he was tired of living with the pain, wanted pain relief, and felt his concerns were not resulting in adequate pain management.R1's progress note dated 6/2/26 at 5:01 p.m., identified R1 was in excruciating pain prior to receiving PRN oxycodone. Staff applied Biofreeze (a cooling pain-relief product that works similarly to putting an ice pack on sore muscles or joints). and repositioned ice packs in addition to administering pain medication. Following intervention, R1 reported some relief and his pain score decreased to 3/10.During an interview on 6/2/26 at 4:37 p.m., nurse practitioner (NP)-A was notified by the surveyor that R1 was currently experiencing uncontrolled left elbow pain and was not due for another dose of oxycodone for approximately 11/2 hours. NP-A stated she had been away the previous week, and the medical director had diagnosed R1 with lateral epicondylitis (tennis elbow) on 5/11/26. NP-A stated R1's pain was believed to be related to nerve impingement (pressure on a nerve) and associated swelling. R1 had previously been provided a sling, which R1 reported helped relieve the pain, but the sling had been lost and recently reordered. NP-A further stated R1 had a brace, and his gabapentin had been increased due to nerve pain. NP-A acknowledged she was aware of R1's left elbow pain and stated oxycodone was unlikely to fully relieve the condition. NP-A stated treatment options were becoming limited and future discussions could include whether hospice services and morphine should be considered for pain management.During an interview on 6/2/26 at 5:13 p.m., interim director of nursing (IDON)-A was (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed R1 was currently experiencing uncontrolled left elbow pain, was crying and doubled over in pain, and was not due for another dose of oxycodone for approximately 11/2 hours. IDON-A acknowledged awareness that R1 had been experiencing left elbow pain.R1's progress note dated 6/3/26 at 6:01 a.m., documented oxycodone 2.5 mg administered for pain rated 2-5. The effectiveness of the medication was documented as Unknown. The note indicated R1 was not giving me a number, just crying in pain. Record review did not identify documentation of a follow-up pain assessment or evaluation of the effectiveness of the medication administration.R1's OT note dated 6/3/26, identified R1 was crying in pain while seated at the breakfast table. OT documented nursing staff were aware of the pain and educating R1 regarding when the next pain medication would be available. OT located R1's elbow brace, applied it, and R1 immediately stated, that's already feeling better. OT continued to evaluate positioning devices and arm supports to improve R1's comfort and positioning. OT documented R1 declined additional interventions to the left upper extremity due to pain. Later that day, OT reviewed R1's pain management plan and educated R1 regarding additional positioning options. OT documented R1 continued to experience left elbow pain that limited positioning and participation in daily tasks.R1's progress note dated 6/3/26 at 2:24 p.m., identified R1 complained of left arm pain rated 8/10 and requested PRN oxycodone; however, staff documented it was too soon to administer the medication. R1 received scheduled gabapentin and a lidocaine patch and agreed to wait until the next PRN dose was available. At 10:40 a.m., R1 received oxycodone for pain rated 9/10. Follow-up assessment at noon identified pain remained at 6/10.R1's progress note dated 6/3/26 at 10:50 p.m., identified R1 reported pain rated 7/10 and received oxycodone 5 mg and an ice pack. Follow-up documentation identified the medication was effective; however, R1 reported only little relief and continued to report pain rated 6/10.During an interview on 6/3/26 at 12:14 p.m., nursing assistant (NA)-A stated R1 was previously largely independent with many activities and required minimal assistance; however, beginning in early to mid-May 2026, R1 developed significant left elbow pain and became weaker. NA-A reported R1 had experienced constant left elbow pain over the previous three weeks and frequently reported pain levels of 10/10 or 11/10. NA-A stated R1 was often observed crying, doubled over, and unwilling to be disturbed due to pain. NA-A further stated she had observed R1 doubled over in pain on multiple occasions and reported other residents had expressed concern regarding the severity of his pain. According to NA-A, R1's pain medication appeared to provide relief for the first few hours after administration; however, once the medication wore off, R1 would again be observed doubled over and writhing in pain. NA-A stated R1's pain was severe and needed to be better controlled.During an interview on 6/3/26 at 1:02 p.m., NA-B stated R1's left elbow pain began a couple of weeks earlier and had become more frequent over the previous several days. NA-B stated she observed R1 holding his elbow, groaning, crying, and requesting staff obtain a nurse because he was experiencing severe pain. NA-B stated she did not believe R1's pain was well controlled and had observed R1 experiencing significantly more pain than in the past. NA-B further stated R1 now required additional assistance with activities of daily living (ADLs) due to pain in his left arm.During an interview on 6/3/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated R1 had developed left elbow pain several weeks earlier and was using a brace for treatment of tennis elbow. LPN-A stated today R1 received oxycodone 5 mg at 4:40 a.m. and began requesting additional pain medication at approximately 8:40 a.m. when he rated his pain as 8/10. LPN-A stated R1 received another dose of oxycodone at approximately 10:40 a.m. when he rated his pain as 9/10. LPN-A stated the medication reduced R1's pain temporarily; however, by approximately 12:55 p.m., R1 reported his pain had increased to 7/10. LPN-A stated R1 also received gabapentin, scheduled acetaminophen, and used a brace for pain management. LPN-A stated she did not believe R1's pain was well controlled and estimated the oxycodone provided relief for only about four hours despite being ordered every six hours as needed. LPN-A stated she was unaware of additional interventions available to address R1's pain other than oxycodone and ice packs.During an interview on 6/3/26 at 3:21 p.m., IDON stated R1 complained of left elbow pain rated 10/10 on 5/24/26. IDON-A stated the provider was notified, R1 (continued on next page)

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